Center for Medicare and Medicaid Innovation (CMMI)

Medicaid Value-Based Payment Model Proposal

I. INTRODUCTION

Background

Congressman Jeff Denham (R-Turlock), the California Medical Association (CMA), and the Stanislaus Medical Society (SMS) are proposing a Center for Medicare and Medicaid Innovation (CMMI) demonstration project in Stanislaus County, California. The project would study the impact of reforming non-Federally Qualified Health Center (FQHC) Medicaid physician payment on access to primary care and specialty physicians in a county with a high concentration of Medicaid patients. Nearly half (45%) of the residents of Stanislaus County are enrolled in Medicaid (called Medi-Cal in California). While these Medicaid patients have coverage, timely access to physician care can be challenging because inadequate payment rates have made it difficult for physicians to fully participate in Medicaid.

Underserved communities with a disproportionate share of Medicaid patients, such as Stanislaus County, also have difficulty recruiting and retaining physicians. Ninety percent of Stanislaus physician survey respondents reported difficulty recruiting new physicians. Half of the local physician respondents are over age 50 and 40% said they plan to retire within the next five years. This portends an access to care crisis in the near future. Physician shortages were reported in nearly every major specialty with the worst being in primary care, psychiatry and the surgical specialties.

The inability to recruit and retain physicians in Stanislaus County is largely due to a disproportionate share of Medicaid patients and low Medicaid payment rates that do not reward value. The California Medi-Cal fee-for-service (FFS) rates are ~50% below Medicare rates. Physicians report low rates from the Medi-Cal managed care plans as well. However, those rates are confidential. We believe that some of the rates are above the Medi-Cal FFS equivalent. Moreover, the local Medi-Cal Health Plan of San Joaquin has implemented some innovative quality and payment programs. Overall, the low rates make it difficult for physicians to fully participate in the Medicaid program and to operate a medical practice in a high Medicaid enrollment community. These Medicaid barriers negatively impact access to care for *all* patients in Stanislaus County, not just Medicaid enrollees. Finally, lack of early and timely access to physicians can increase emergency department visits and hospital admissions that could have been avoided. Because patients cannot get early access to a doctor, their conditions worsen and become more complicated and costly to treat - adding pressure to state and federal Medicaid budgets.

Payment Reforms Summary

The payment reforms contemplated in this pilot are aimed at 1) increasing the physician workforce by retaining new physicians who completed their residency training in the Central Valley; and 2) improving early access to physicians through value-based payments which would reduce avoidable emergency department visits and hospital admissions. The reforms include:

- Supplemental Medicaid payments (above Medicare payment levels) to incentivize new physician residents-in-training to remain in the area after they finish their medical education.

- Bonus payments for providing preventive care services;
- Case management payments for managing chronic conditions;
- Payment for e-consults between primary care physicians and specialists to alleviate the specialty waiting times;
- Allow physicians to collect 100% of the Medicare Physician Fee Schedule amount for treating Medicare-Medicaid dual eligible patients by increasing the Medicaid payment rate to Medicare levels in order to cover the 20% patient copayment;
- Increasing general payment rates to at least Medicare levels for FFS and capitation.

Goals

The goals of this project are to improve the delivery and accessibility of quality physician care to diverse Medicaid patients, to increase the overall physician workforce in Stanislaus County, and to reduce costs. Payment and delivery reform can be achieved on a budget-neutral basis by reducing unnecessary costs.

A specific focus also will be on the retention of physicians finishing their residency training in the Central Valley. Currently, less than half of newly-trained physicians remain in the area. This will be an important pilot program for underserved communities.

The stakeholders believe that this is an important project to improve access to care for a diverse patient population that has historically suffered from health care disparities. The proposed preventive care and chronic care payments have the potential to improve the overall quality of care. Moreover, paying the full Medicare rate for Medicare-Medicaid dual eligibles will provide a significant incentive for physicians to accept these more complex, vulnerable patients.

The CMA and SMS are also working to partner with the two local Medi-Cal managed care plans – the Health Plan of San Joaquin and Health Net. Their involvement is key to the success of the program. The Health Plan of San Joaquin is a high quality plan that has successfully worked with local physicians to improve the health status of patients in Stanislaus County. This project would build on those programs that are working.

This is a unique project to inform and improve the long-standing Medicaid access to care problems in underserved communities. The results will be informative for the hundreds of highly- concentrated Medicaid regions across the country experiencing low physician Medicaid participation, general physician shortages, and barriers to quality care.

II. STANISLAUS COUNTY HEALTHCARE DEMOGRAPHICS

Stanislaus County is located in the Central Valley region of California ~90 miles east of the San Francisco bay area. It has an ethnically diverse, low-income patient population. According to 2017 census estimates, it's population is around 550,000 with 45% of residents enrolled in Medicaid.

Stanislaus County Medicaid Coverage Facts (CA Dept of Health Care Services)

- Nearly half (45%) of Stanislaus residents are covered.
- 1/3 of all Californians are covered by Medi-Cal (14 million).
- ½ of all California Children are covered by Medi-Cal (>5 million).
- ½ of all Disabled Californians are covered by Medi-Cal.
- 250,327 Medi-Cal Patients in Stanislaus County.
- 22,000 are Medicare/Medicaid dual eligible.
- 85% of all California Medi-Cal patients are enrolled in managed care.
- In Stanislaus, 52% enrolled in the Health Plan of San Joaquin; 28% enrolled in Health Net.
- 130,100 Medi-Cal patients are enrolled in the Health Plan of San Joaquin.
- 69,789 Medi-Cal patients are enrolled in Health Net.

Stanislaus County Health Care Providers

a. Hospitals

According to the California Office of Statewide Planning and Development (OSHPD), there are nine hospitals in Stanislaus County.

Central Valley Specialty Hospital, Modesto
Doctors Behavioral Health Center, Modesto
Doctors Medical Center, Modesto
Emanuel Hospital, Turlock
HealthSouth Rehabilitation Hospital, Modesto
Kaiser Permanente Hospital, Modesto
Memorial Medical Center, Modesto
Oak Valley Hospital, Oakdale
Stanislaus Surgical Hospital, Modesto

b. Federally Qualified Health Centers (FQHCs)

There are three federally-funded Health Center organizations in Congressman Denham's district that serve nearly 200,000 patients. Community Medical Centers has two sites, Golden Valley Health Center has 19 locations, and Livingston Community Health has three sites. (National Association of Community Health Centers)

The local Medicaid managed care plans contract with the FQHCs to provide primary care coverage.

c. Physicians

There are 990 California licensed physicians practicing in Stanislaus County.[1] The vast majority of physicians (948 active and retired) are members of the CMA and the SMS.

[1] Medical Board of California, 2017.

Of the CMA/SMS membership:

Number of Primary Care Physicians: 316

Family Medicine	134
Internal Medicine	83
OBGYN	48
Pediatrics	51

The number of primary care physicians lost due to retirement since 2015: 15

Family Medicine	5
Internal medicine	5
OBGYN	1
Pediatrics	4

The number of primary care physicians lost due to moving out of area since 2015: 56

Family Medicine	21
Internal Medicine	14
OBGYN	10
Pediatrics	11

Number of Primary Care Physicians who stayed in Stanislaus County after Residency Training: 12

2015	5
2016	3
2017	4

d. Large Integrated System Medical Groups

There are two large integrated medical groups in Stanislaus County that do not serve Medicaid patients: Permanente Medical Group (TPMG) part of Kaiser Permanente Health Plan

Sutter Gould Medical Group

e. Physician Graduate Medical Education Residency Programs

1. Valley Consortium for Medical Education– Modesto

Family Medicine	9 residency positions/year
Orthopedic Surgery	3-4 residency positions/year

Number of Primary Care Physicians who stayed in Stanislaus County after Residency Training:

2015	5

2016	3
2017	4

2. San Joaquin General Hospital in Stockton, CA (not in the district but nearby)

Specialty and number of Residency Positions

Family Medicine	7
Internal Medicine	7
Medicine Preliminary	3
General Surgery	3
Surgery Preliminary	2

f. Health Plan of San Joaquin: Non-Profit County-Operated Plan

130,100 total Medicaid enrollees in Stanislaus County

37,300 Medicaid Expansion Adults

57,700 children

2,000 pregnant women gave birth in 2017

3,360 Medicare/Medicaid dual eligibles

7,000 disabled

Contract with 182 primary care physicians (not including NPs or PAs) and 420 specialists.

Contract with FQHCs for its primary care network.

77% (140) of the contracted primary care doctors are employed by an FQHC.

Also contract with physicians outside Stanislaus County.

The plan met the California timely access requirements for provider appointment wait times 85% of the time.

Met the required appointment wait times for urgent care 59% of the time.

g. Health Net: Private, For-Profit Health Plan

69,789 total Medicaid enrollees in Stanislaus County

III. PHYSICIAN SHORTAGES AND MEDICAID ACCESS TO CARE PROBLEMS

There is a severe shortage of doctors in the rural Central Valley regions of California negatively impacting access to care.

The California Central Valley has the lowest physician to patient ratios in the state and some of the lowest in the nation. The Central Valley has difficulty attracting and retaining physicians because of the disproportionate share of underfunded Medi-Cal, uninsured, and Medicare patients. Many physicians cannot maintain a practice, particularly in primary care, with such a difficult payer mix. According to the Council on Graduate Medical Education,

- The U.S. is projected to have 90,000 fewer physicians than the country needs by 2025. Because physician training can take years, physician shortages in 2025 need to be addressed now.
    - California ranks 32nd in physician access.
    - California needs 8,243 additional primary care physicians by 2030 – a 32% increase.
    - 6 of 9 California regions are facing a primary care provider shortage – including Stanislaus County and the Central Valley.
    - 23 of California's 58 counties fall below the minimum required primary care physician-to-population ratio – Stanislaus County.

The **Horizon 2030 report** provided a sobering analysis of the state's primary care workforce needs while detailing key opportunities to meet the needs of tomorrow. With six of nine California regions (including Stanislaus) experiencing a primary care provider shortage, and a ratio of primary care physicians in Medicaid that is half the federal recommendation, California ranks 32nd in physician access. The report estimates that California will need 8,243 additional primary care physicians by 2030 and provides a stark reminder that the primary care workforce shortage has reached a critical point and will continue to devolve if California and the federal government don't take immediate action.

Medicaid Access to Care Problems: California and Stanislaus County

Access to care for California's 13.5 million Medi-Cal patients has been a chronic problem because of long-term under funding. When physicians are unable to treat Medi-Cal patients because of low payment rates, access to care suffers, patient conditions worsen, and avoidable emergency department visits and hospitalizations result. Emergency physicians are an integral part of the local safety net that ensures patients can access care when they need it. The goals of this project are to ensure that patients have more timely access to care to primary and preventive care to avoid more costly conditions.

Generally, the studies show inadequate payment rates and therefore, significant access to care problems: According to the Urban Institute Studies of the California Medi-Cal Fee-for-Service program and a July 2014 Government Accountability Office report:

- Medi-Cal physician reimbursement rates rank 48th out of 50 states.
- Medi-Cal rates are an average 45% less than Medicare reimbursement rates.
- Medi-Cal rates are 20% less than the national average Medicaid rates.
- Medi-Cal pays $21.60 for a patient office visit (99213), while other insurers pay 3 times more.
- 85% of Medi-Cal patients are enrolled in managed care plans and the rates and access problems vary between plans and the fee-for-service (FFS) program.
- Medi-Cal pays 61% lower than private insurance.

- California has some of the highest costs in the country to operate a medical practice.

Therefore, according to the California Health Care Foundation and the University of California-San Francisco: "Physician Participation in Medi-Cal: Is Supply Meeting Demand?" June 28, 2017,

- Only 69% of California physicians accepted any Medi-Cal patients, compared to 77% that accept Medicare. (2014 Provider Survey)
- 35% of California physicians are caring for 80% of the Medi-Cal patients demonstrating a mal-distribution of physicians.
- Primary care physicians were less likely to have Medi-Cal patients in their practice than patients with private health insurance.
- The increase in the number of FTE physicians participating in Medi-Cal did not keep pace with the growth in Medi-Cal enrollment so the ratio of physicians to Medi-Cal patients decreased.
- For both primary care and non-primary care physicians, the ratios of physicians to Medi-Cal enrollees fell below national and state recommendations.

It is difficult for physicians to maintain a viable medical practice on such low rates.

UCSF researchers concluded that further investments and improvements are needed to ensure adequate access to care. The report discusses approaches to address this challenge, including:

- Increasing provider reimbursement
- Reducing administrative burdens for physicians
- Increasing opportunities for physicians to train in communities where physician shortages are greatest, and recruiting new doctors from within those communities.
- Taking additional steps to increase the capacity of existing physicians and improve the overall efficiency of care provided to Medi-Cal patients, such as
- Adopting health plan and provider payment reforms to foster team-based care and encourage providers to pursue alternatives to face-to-face visits.
- Expanding the integration of behavioral health and primary care, so that primary care providers get the support they need to care effectively for patients with mental health and substance use conditions.

In a May 2018, Prop 56 CMA survey of the physician membership statewide, physicians reported that a number of changes to the Medi-Cal program would be needed before they could accept Medi-Cal patients or increase the numbers accepted, with 83% stating that increased reimbursement is needed. When physicians are unable to treat Medi-Cal patients, patients cannot get timely access to care.

According to the Medicare geographic practice cost index, California has some of the highest cost regions in the country to operate a medical practice. This exacerbates the impact of the low Medi-Cal reimbursement rates on physicians. For a basic office visit without copayments, California reimburses a physician $16, far less than the cost to provide the service. An established patient office visit is paid $21.60 by Medi-Cal while Medicare pays three times that at $76.72 and adjusts for California's higher practice costs.

Numerous studies performed by credible independent research institutions examining access to care in California's Medi-Cal program have all concluded that access to care is a problem.[2]

IV. CMA-SMS MEDICAID SURVEY OF PHYSICIAN MEMBERSHIP IN STANISLAUS COUNTY

In 2018, the CMA/SMS conducted a survey of the local physicians to better understand physician participation in the Medi-Cal fee-for-service and managed care programs, payment rates, and physician perceptions about access to care in Stanislaus County. Both organizations sent an electronic "survey monkey" survey to the Stanislaus physician membership via email. 7.8% of physicians responded. It was not a random sample survey.

The results of the survey can be found at: https://www.surveymonkey.com/results/SM-VMH65QP9L/;

Survey Results: Overview

The survey results demonstrate substantial physician shortages and access to care problems in Stanislaus County. It appears that these shortages and access to care problems are partly due to the low Medicaid payment rates in a county with a high concentration of Medicaid patients. Physicians cannot sustain a medical practice when 45% of a county's population is in a program that pays 50% less than Medicare. Physicians reported low rates in both the Medicaid fee-for-service program and Medicaid managed care. The access problems are substantial. Every major physician specialty is experiencing shortages. 82% of physicians said their patients wait many weeks and months for a referral to a specialist. Moreover, 90% of Stanislaus physician respondents reported difficulty recruiting new physicians and 40% said they plan to retire or leave the area within the next five years. The results confirm there is a need to reform non-FQHC Medicaid payment in underserved areas in order to improve physician participation in Medicaid. Without adequate physician participation, unnecessary emergency department visits and hospital admissions will rise. Patient conditions will worsen and costs will increase. However, overall physician workforce shortages in high Medicaid enrollment regions must also be addressed to protect access to care for all.

Summary

- The physician respondents in Stanislaus County are aging (half are over the age of 50);
- 90% report difficulty trying to recruit new physicians and 40% said they plan to retire or leave the area within the next 5 years which points to a real access to care crisis in the near future.

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[2] Perrone, C. 2018. Medi-Cal Enrollees' Access to Care. California Health Care Foundation. Presentation to the California Assembly Select Committee on Health Care Delivery Systems and Universal Coverage. Retrieved from: https://www.chcf.org/blog/chcf-testifies-access-care-medi-cal-assembly-select-committee/; See also, Tater, M; Paradise, J; Garfield, R. 2016. Medi-Cal Managed Care: An Overview and Key Issues. Henry J. Kaiser Family Foundation, The Kaiser Commission on Medicaid and the Uninsured. Retrieved from: http://files.kff.org/attachment/issue-brief-medi-cal-managed-care-an-overview-and-key-issues.

- 52% said it would require higher than Medicare reimbursement rates for treating Medicaid patients in order to recruit new physicians to the area because of the large numbers of Medicaid patients.
- Physicians reported shortages in every major specialty with the worst shortages being in psychiatry and primary care. Dermatology, orthopaedic surgery, neurosurgery and ophthalmology were close behind.
- 82% of respondents reported that it takes "weeks" and even "months" to obtain a referral to a specialist.
- The majority of physicians responding contract with a Medicaid managed care plan but 57% said they are not accepting new plan patients which demonstrates a substantial access to care problem.
- 78% of respondents contracting with the Heath Plan of San Joaquin, and 88% with Health Net said they are paid the equivalent of Medi-Cal fee for service rates.
- Only 43% of respondents are participating in the Medicaid fee-for-service program. 72% of all respondents said they are not participating because of the low rates.

The Medi-Cal fee-for-service rates are 50% below Medicare. These low rates are paid in both the FFS and the Managed Care program, according to contracting physicians. It is negatively impacting physicians' ability to participate in Medicaid or accept new patients.

Survey Highlights

Physician Information

- Physicians in nearly every major specialty responded. 38% are family physicians.

- Half of the physician respondents are over the age of 50; 75% are over the age of 40. This demonstrates the aging of the Stanislaus County physicians and their inability to recruit younger physicians.

- 40% are in solo/small practice; 37% in medium-large groups; 22% are in the Permanente Medical Group which does not participate in Medi-Cal.

- 27% of physician respondents are employed by an FQHC.

- 30% of physicians said that only 5-10% of their patients are enrolled in Medi-Cal. This shows that most physicians are only able to accept a few Medi-Cal patients. A smaller subset of physicians accept the majority of Medi-Cal patients.

Medi-Cal Managed Care

- 70% of respondents contract with the Health Plan of San Joaquin for Medi-Cal.

78% said they are paid the equivalent of Medi-Cal FFS rates.
22% are paid at Medicare levels or above.

- 58% of respondents contract with Health Net.
  88% said they are paid the equivalent of Medi-Cal FFS rates.

- 57% of those contracting with a health plan are not accepting new Medi-Cal patients.

- 44% of all respondents said they are not participating in Medi-Cal Managed Care because of the low rates.

Medi-Cal Fee-For-Service Program

- 43% of respondents participate in the Medi-Cal FFS program

- 69% of those participating in FFS are accepting new patients

- 72% said they are not participating in Medi-Cal because of the low FFS rates.

Access to Care

- Nearly every major physician specialty is experiencing shortages.
  Respondents reported physician shortages in the following specialties. The worst shortages are listed first.

  1. Psychiatry
  2. Primary Care
  3. Dermatology
  4. Orthopaedics, Ophthalmology, Nuerosurgery, and "Other"
  5. Allergy and Immunology
  6. Pediatrics (Some respondents may be included under Primary Care)
  7. OBGYN (Some respondents may have included under Primary Care)
  8. General Surgery
  9. Cardiology

- Regarding wait times to obtain a referral to a specialist, 82% of respondents reported difficulty finding specialists who could see patients within a few weeks or even months.
  50% said it takes "weeks"

  32% said it takes "months"

  25% of respondents said they were forced to seek referrals outside the county.

Physician Retention and Recruitment

- 90% of respondents said they are experiencing difficulty recruiting new physicians to the area.
- 40% said they plan to retire or leave the area within the next five years.
- 52% of practicing physicians said it would require reimbursement rates above Medicare levels to enable young physicians to remain in the area after residency training.

It should be noted that the Health Plan of San Joaquin unofficially reports payment rates that are above the Medi-Cal Fee Schedule equivalent and in some instances, above the Medicare fee schedule. The rates are confidential.

V. PROPOSED PAYMENT MODEL SOLUTIONS

Overview

The evidence presented in the previous sections clearly support the need for a Medicaid value-based payment demonstration program that focuses state and federal resources where they are needed most and improves overall access to quality care. It is a manageable demonstration program consisting of 900 physicians and 250,000 diverse Medicaid beneficiaries in a rural county where nearly half of the residents are enrolled in Medicaid. It is also unique because it focuses on improving the general physician shortages.

This proposal outlines a comprehensive value-based payment model to address the main shortcomings of the current Medicaid payment system and the challenges of the Medicaid health care delivery system in California. These innovative payment and delivery models would improve timely access, clinical outcomes, quality, care coordination, and overall physician shortages in an underserved area. There is also an opportunity to achieve real cost savings. By improving timely access to physicians, some costly conditions and related hospitalizations can be avoided.

The model provides:

- A supplemental Medicaid payment for new physicians who remain in Stanislaus upon the completion of their residency training.
- A general base payment increase to incent physician participation in Medi-Cal and thus, increase access to both primary care and specialty physicians. Such an increase will also help to retain and attract new physicians to Stanislaus County which has a disproportionately high number of Medi-Cal patients.
- An additional preventive care payment to incent physicians to provide preventive services and to motivate their patients to make appointments to receive such care. As the studies show, when preventive care is used, illness and disease are caught early which help patients avoid or

better control more serious health care conditions. Preventive care also helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable.

- Payments for e-consults between primary care physicians and specialists to address the specialty shortage problems. It would improve access to specialists and help primary care physicians better manage their patients conditions.
- Payments to better manage and incent treatment for patients with complex medical conditions, particularly the elderly and disabled. Two-thirds of Medicaid spending is for care provided to the elderly and disabled who only comprise one-quarter of all Medicaid patients. [3]
- Payments to incent access and the coordination of care for the rapidly rising population of Medicare-Medicaid dual eligible patients in California. Duals make-up one-fourth to one-third of all Medicare patients in most California counties.

Proposed Payment Reforms

The specific payment reforms for this demonstration project are described below. However, in order for this project to be a success, we propose that the following information and technical assistance be provided to physicians:

- Physicians need better data from the State of California and CMS to understand the Medicaid total costs of care related to their patients so they can better manage those costs;
- Physicians need access to better health information exchanges for case management platforms;
- The Medicaid manage care rates must be risk-adjusted to include patient socioeconomic status, ethnicity and other social factors. The Medicare HCC risk adjustment system must be more timely and relevant to current chronic conditions;
- Because social determinants of health are becoming better understood, we would also propose that physicians be provided with basic information about where to refer patients for non-health care needs. They need local Stanislaus County and California State Social Services contact information to share with their patients; and
- As the number of patients with chronic conditions continue to rise, physicians need to be reimbursed for time spent non-face-to-face with patients coordinating their care.

1. Medicaid Retention Bonus for Physicians Who Remain in Stanislaus County After Completion of Their Graduate Medical Education Residency Training

The Valley Consortium for Medical Education (VCME) was founded in 2009 as a non-profit, community benefit organization to create and foster graduate and undergraduate medical education in the Central Valley. Located in Modesto, California, the Consortium has participation from major health care

[3] Kaiser Family Foundation, Medicaid Facts, 2017.

organizations in Stanislaus County, and affiliations with the University of California, Davis School of Medicine and the Midwestern University/Arizona College of Osteopathic Medicine .

The Consortium members together represent over 800 acute care hospital beds, more than 150,000 emergency room visits, 24,000 major surgical cases and over 50,000 admissions annually. The training sites combine high-quality faculty with high-technology settings to deliver first class training experiences for residents and medical students. Community-based teaching keeps the training practical, relevant and real world for graduates to quickly assimilate into diverse community settings throughout California's Central Valley.

Prior to the formation of the consortium, from 1975-2009, the Stanislaus Family Medicine Residency program trained nearly 300 physicians. VCME now has two ACGME approved residency programs. The Family Medicine program matches 9 residents on average each year and the new Orthopedic Surgery program matches 2-4 residents each year.

There is a larger graduate medical education residency training program at the San Joaquin General Hospital in nearby Stockton, California. It is affiliated with the University of California, Davis School of Medicine. It has three residency programs in family medicine, internal medicine and general surgery. It matches approximately 22 residents each year.

It has been extremely difficult to attract new physicians to the Central Valley. Ninety percent of the Stanislaus physician survey respondents reported difficulty recruiting new physicians to the area. Therefore, many local physicians believe that more should be done to retain those physicians who complete their graduate medical education residency training in Stanislaus County. These new physicians have set down roots in the community and with the right incentives, could be convinced to stay. There are at least 12 graduating residents each year yet, according to the Stanislaus Medical Society, only an average of four residents remain in the community each year.

This proposal would provide a supplemental Medicaid payment for services provided to Medicaid patients for physicians who completed graduate medical education residency training within the San Joaquin Valley region of California (Stanislaus and San Joaquin Counties) and agree to stay and practice in Stanislaus County for 5-10 years.

Because it is difficult to compete with the much higher rates paid by the Federally Qualified Health Centers for primary care, the supplemental payment must be meaningful. 52% of physician survey respondents said it would require reimbursement rates above Medicare levels to enable young physicians to remain in the area after residency training. Most physician group recruiters in the region report that it requires a $250,000 annual equivalent salary to attract primary care physicians and at least $300,000 for specialists.

As emphasized earlier, the San Joaquin Valley regions have half as many physicians per 100,000 residents as the greater bay area (CHCF)[i]. The physician population is aging (half the respondents were over the age of 50) and distributed unevenly between urban and rural California regions. A first step in addressing the shortages of doctors in the central valley is to retain those physicians who are already practicing in Stanislaus and to incentivize the recently trained to remain in the community.

Proposal: Adjusting the reported salary requirements for Medicare Relative Value Units (RVUs), the proposed supplemental Medicaid payment rate would ensure that total Medicaid reimbursement is no less than 200% of the Medicare Physician Fee Schedule.

2. Value-Based Payment Reforms

Nearly 85% of the Medi-Cal patients in Stanislaus are enrolled in a Medicaid managed care plan. At least one plan bears financial risk and capitates their primary care provider payments. Therefore, the plan and the primary care physicians are incentivized to maximize value through improved health and manageable costs. Specialists are paid on a fee-for-service basis. However, managing limited Medicaid resources with a complex patient population, and severe physician shortages can be challenging.

While the Health Plan of San Joaquin has a solid record of providing timely access to the region's Medi-Cal patients, additional resources could help the plan shore-up the gaps in care.

According to two CHCF studies,[4] the San Joaquin Valley regions have half as many physicians per 100,000 residents at the greater bay area. In Stanislaus, there are 52 primary care physicians per 100,000 population (282 PCPs for a total population of 538,000). There are 81.5 specialists per 100,000 population (439 specialists). [5]

According to Physician Participation in Medi-Cal: Is Supply Meeting Demand" California HealthCare Foundation (CHCF) June 2017, the number of physicians participating in Medi-Cal did not keep pace with the growth in enrollment and the ratios of physicians to patients fell below both state and national recommendations. Therefore, CHCF recommended increasing provider reimbursement as one way to increase physician participate in Medi-Cal and access to care.

A. Medicaid Base Rate Increase to at least 120% of the Medicare Physician Fee Schedule

In order to increase physician participation in Medi-Cal, this proposal would increase the base fee-for-service and capitation payment rates for both the Medi-Cal fee-for-service program and the Medi-Cal managed care plans. Physicians involved with the California Medi-Cal County Organized Health Systems (COHS) unofficially report that these plans reimburse primary care providers at approximately 120% of the Medicare physician fee schedule (or equivalent if capitated) and specialists receive 100-130% of the Medicare physician fee schedule with an additional payment of $150 per new patient office visit. [6] Plans that pay these rates are working to ensure they have access to care for their Medi-Cal enrollees and an adequate overall network of doctors. These plans argue that if there is an adequate network, patients can get care from physicians and avoid unnecessary visits to the Emergency Department and the hospital.

Because this COHS rate information is confidential, it is difficult to report. Therefore, CMS should do an examination of the experience of the County Organized Health System Medi-Cal managed care plans

[4] California's Physicians: Headed for a Drought," CHCF

[5] "California Maps: How Many Primary Care and Specialists Physicians are in Your County, August 2017." CHCF/DHCS

[6] County Organized Health System (COHS) informal physician interviews

across California. The COHS physicians unofficially report that the higher reimbursement rates have increased physician participation and reduced emergency department episodes and costly hospitalizations making it a budget neutral transaction for both the state and federal government.

Proposal: Increase Medi-Cal Fee-for-Service rates to at least 120% of the Medicare Physician Fee Schedule. Increase Medi-Cal managed care fee-for-service and capitation rates to at least the equivalent of 120% of the Medicare Physician Fee Schedule. Finally, capitation rates must be expressed in a Medicare Physician Fee Schedule equivalent rate so plans and providers can appropriately assess the adequacy of reimbursement rates.

B. Preventive Care Quality Incentive Program

This proposal would build on the Health Plan of San Joaquin's excellent Quality Incentive Program that provides additional quality incentive payments for the provision of certain HEDIS preventive care services. Providing such care potentially reduces preventable diseases for Medicaid patients while reducing health care expenditures for both the state and federal government. The Health Plan of San Joaquin (HPSJ) provides a capitated per member per month payment to each contracting primary care provider. In addition, the plan provides a $50 quality incentive payment for each preventive service provided by a primary care physician. Such services include cervical cancer screening, comprehensive diabetic care and hemoglobin A1c testing, well-child visits, immunizations, nutrition counseling, child and adolescent visits, medication monitoring, and prenatal and postpartum care. Additional services could be added to this list, such as screening mammography and the HPV vaccine. But the HPSJ program pays for valued preventive care that can reduce overall health care costs and improve clinical outcomes and it should be supported and modeled.

Our understanding is that the HPSJ's program is funded with reserves and we would propose that this incentive program be funded directly by the State of California and the federal government.

The Integrated Health Care Association (IHA) in California has also developed a standard set of preventive care quality measure metrics for California's Medicaid program. CMS could consider those measures.

Because of the extremely high Medicaid reimbursement rates for Federally Qualified Health Centers, we do not think additional incentive payments to FQHCs are appropriate. However, it is important for CMS to incentivize the provision of high quality preventive care – particularly for non-FQHC contracted physicians.

The Medicare Advantage Star Rating system is another system that could be replicated in Medi-Cal managed care to promote and incent preventive care services.

The cost-savings achieved by providing preventive services has been well-documented. According to a California Health Care Foundation (CHCF) study, "Medi-Cal Matters," every $1 spent on preventive care saves California $3 in overall health care costs. [7]

[7] CHCF "Medi-Cal Matters," Prevention Institute 2007.

Therefore, this proposal would provide an additional $50 physician incentive payment for the provision of each specified preventive care service, in both the fee-for-service and Medi-Cal managed care programs. We support the HPSJ list of eligible preventive care services with the addition of screening mammography and the HPV vaccine.

C. Telehealth or e-Consult Payments for Consultations Between Primary Care Providers and Specialists

Because there is such a shortage of specialists in the San Joaquin Valley region, many Medicaid patients can wait weeks and months and have to travel long distances to see a specialist. Their conditions worsen and become more difficult to manage and costly to care for.

To improve access to specialist care in Stanislaus, this proposal includes a plan to provide reimbursement for specialists who provide e-consultations with primary care providers, at least until the patient can obtain an appointment with the specialist.

We believe that CPT codes 99446-99449[8] could be used to bill and document such services. Telehealth codes could be used as well if the patient is present. Another option is for the local health plans to contract with e-consult specialist services, such as RubiconMD,[9] that provides a panel of specialists available to consult with primary care providers for a per member per month fee. Such non-face-to-face consults and specialist "visits" are not reimbursable under the current system. But paying for access to specialists through e- consults with primary care providers would be major step forward in paying for value. E-consult visits could, of course, also include the patient.

Enabling primary care physicians to easily and quickly discuss their patient's conditions with specialists helps them provide better, more timely access to care. It improves the patient experience by potentially avoiding long travel times, wait times and unnecessary tests and ER visits. It removes barriers to comprehensive care through timely advice. And it helps primary care physicians effectively manage their patients care. It would reduce costs and patient suffering. RubiconMD claims that an average of $370 is saved per e-consult.

D. Payments for Managing Chronic Conditions

According to the Kaiser Family Foundation, two-thirds of Medicaid spending is for care provided to the elderly and disabled who only make-up one-quarter of all Medicaid enrollees.[10] Because of the current Medicaid reimbursement and delivery systems, managing and coordinating care for these patients is difficult. Below is an excerpt from the Center for Healthcare Quality and Payment Reform's recent paper entitled, "Why Value Based Payment Isn't Working and How to Fix it."[11] Harold Miller, the author, outlines an innovative payment proposal to better reimburse physicians for managing the care of patients with chronic conditions.

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[8]AMA, Current Procedural Terminology (CPT) 2018, Evaluation and Management/Non-Face-to-Face Services; Interprofessional Telephone/Internet Consultations, Codes 99446-99449

[9] RubiconMD 2018, https://rubiconMD.com;

[10] Kaiser Family Foundation, Medicaid Facts, 2017.

[11] "Why Value-Based Payment Isn't Working and How to Fix it," Harold Miller, Center for Healthcare Quality and Payment Reform, October 2017.

This is a more reasonable way to provide value to the Medicaid program by ensuring that patients have access to care and physicians have the resources to appropriately manage the care of their chronically ill patients.

Therefore, this model would propose to make payments to physicians caring for chronically-ill Medicaid patients in the following manner: (It would apply to both the Medi-Cal fee-for-service program and the Medi-Cal managed care plans)

Excerpts from "Why Value-Based Payment Isn't Working and How to Fix It":
Management of a Chronic Condition*: A patient who is diagnosed with a chronic condition will need care over an extended period of time, potentially for the rest of their life, so the types of one-time bundled payments used for acute conditions will not work well for management of chronic conditions. In addition, the initial period following diagnosis of a chronic disease often involves considerably more time in educating the patient about the disease, adjusting medications to achieve the best balance of results, side effects, and cost, etc., than later time periods. Moreover, the initial period and later periods do not necessarily have to be managed by the same team of providers. Consequently, defining a separate payment for the chronic care management that is delivered in the initial period versus the care delivered on a longer term basis allows for more appropriate definitions of provider teams, outcomes, and pricing.*

Bundled Payment for Initial Treatment of Chronic Conditions.
When a patient is newly diagnosed with a chronic condition or combination of conditions (or the patient is being treated for the condition(s) for the first time following a diagnosis determined in the past), a Chronic Care Management Team selected by the patient should receive a one-time or monthly Bundled Payment to deliver initial treatment, education, and self-management support services for a pre-defined period of time. The Team should be accountable for meeting standards of quality in the delivery of the services (including coordinating those services with treatments the patient may be receiving for other conditions), and for achieving short-term outcomes for the patient.

Monthly Bundled Payment for Continued Management of Chronic Conditions.
After initial treatment has been completed, Chronic Care Management Team selected by the patient should receive monthly Bundled Payments to deliver ongoing treatment, education, and self-management support services to patients with a chronic condition or combination of conditions. The Team should be accountable for meeting standards of quality in the delivery of the services (including coordinating those services with treatments the patient may be receiving for other conditions), and for achieving both short-term and longer-term outcomes.

E. Caring for Medicare-Medicaid Dual Eligible Patients

According to the Kaiser Family Foundation and the California State Department of Health Care Services, in 2017, there were 1.4 million dual eligible patients in California representing 11% of the total Medi-Cal population. They represent nearly one-fourth of all Medicare patients. In Stanislaus County, there are 32,457 seniors and disabled on Medi-Cal. Nearly 14,000 are over age 65.

Many physicians are disincentivized from caring for elderly and vulnerable dual eligible patients because they require more time to diagnose and manage multiple, complex medical conditions on extremely low rates. Because of the time and complexity, current reimbursement rates do not cover a physician's cost to provide such care. Many physicians in rural areas, such as Stanislaus County, don't have the time and resources to coordinate their care with other physicians or find specialists who can see new patients. It

is extremely difficult to manage the care of a dual-eligible patient on limited Medicaid resources. But these physicians have treated such patients in their communities for many years and feel a strong obligation to continue to help them.

Because physicians are prohibited from collecting the Medicare copayment from a dual patient, they depend on Medicaid to collect the 20% balance on the Medicare fee. However, the California Medi-Cal fee schedule is so low that physicians do not collect anything. They receive only 80% of the Medicare fee schedule for treating extremely complex patients. This is a strong disincentive to provide care. Moreover, it does not give physicians the time and ability to coordinate care with other specialists. There needs to be a better payment methodology for managing patients with chronic conditions. Finding better ways to manage dual eligible patients will not only improve the quality of their care and health care outcomes but reduce unnecessary ER visits and hospital admissions. The potential to better manage costs is enormous.

This model proposes two compatible ways to improve care and reduce costs for dual eligible patients.

1. **See Section D above "Payment for Managing Chronic Conditions."**

2. **Medicaid would reimburse physicians in Stanislaus County (and across California) the Medicare Physician fee schedule amount for caring for a dual eligible patient so that physicians collect the equivalent of 100% of the Medicare Physician fee schedule for any services provided. Providing full Medicare reimbursement for a Medicare dual eligible patient would give physicians more reasonable resources to manage their care. It would greatly improve access to care for such vulnerable patients. It would also reduce costly ER visits and hospitalizations.**

VI. POTENTIAL FOR COST SAVINGS

Ensuring access to primary care and other essential health services for Medicaid patients helps to improve efficiency and reduce costs for state and federal Medicaid programs. Research shows there are substantial health care savings when patients have access to primary and preventive care services. The Dartmouth Atlas studies have shown that in regions where there is less access to primary care providers, health care spending is higher. Dartmouth researchers suggest that the U.S. could save as much as 30% on health care costs if access to primary care improved.[12] The Johns Hopkins School of Public Health found that in markets where primary care physicians provide the majority of care, patients are healthier and costs are lower.[13] A recent study concluded that Medicare spending was $1,781 lower per beneficiary that mostly saw a primary care physician to manage chronic diseases rather than a specialist.[14]

[12] Dartmouth Medical School, 2006. The Care of Patients with Severe Chronic Illness: An Online Report on the Medicare Program.

[13] Starfield, B., et. al. 2005. The Effects of Specialist Supply on Population's Health: Accessing the Evidence, Health Affairs, 24:w97-w107.

[14] Bynum, J et al. 2017. "Outcomes in Older Adults with Multimorbidity Associated with Predominant Provider of Care Specialty" Journal of the American Geriatrics Society. 65:1916-1923.

Without proper access to care, Medi-Cal beneficiaries rely on emergency departments that are important local safety net providers. However, the costs of treatment increase when patient conditions worsen because they could not access primary care or specialist physicians. According to a poll conducted by the American College of Emergency Physicians,[15] emergency department visits are on the rise. Because previously uninsured individuals now have Medicaid coverage but can't find a provider, they have more readily accessed the emergency department for care. The emergency department often becomes the only place they can obtain health care services in a timely manner. Thus, avoidable emergency visits and hospitalizations and their related costs are on the rise. An ER visit often costs ten times as much as an urgent care visit because of the hospital overhead costs and the patient's condition.[16] The result of emergency department overuse by Medi-Cal patients is that emergency physicians and hospitals lose millions if not billions of dollars every year treating patients who should have been treated earlier in a physician's office or clinic. It also places unnecessary burdens on state and federal Medicaid budgets.

California data shows increased emergency department use, particularly among Medi-Cal patients. In the first quarter of 2013, almost 800,000 Medi-Cal beneficiaries visited the emergency department. However, that number increased to about 1.4 million by the fourth quarter of 2016.[17] These trends reflect Medi-Cal patient's inability to access needed preventive services and obtain primary care and specialist appointments in a timely manner.

We have requested from CMS the Stanislaus County Medi-Cal data on emergency department utilization and costs as well as hospital bed day costs for comparison purposes and to create a baseline from which to measure future expenditures under this model.

Based on the numerous studies and the experience of the California Medicaid County Organized Health Systems (COHS) discussed in previous sections, there are significant savings to be gained by increasing access to primary care and specialist physicians. The value-based payment models contemplated in this proposal would increase access to primary care and specialist physicians which would reduce costs.

Moreover, the provision of more preventive care proposed here has been well-documented to achieve a three-fold savings. Rubicon, MD, the e-consultation service mentioned in the e-consult payment section has documented significant cost savings. And finally, the chronic care bundled payment proposal from the Center for Healthcare Quality and Payment Reform will also create efficiencies. See the discussion in those sections.

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15 ACEP Now. May 6, 2015. Emergency Department Visits Increasing, ACEP Poll Shows. American College of Emergency Physicians. Retrieved from: http://www.acepnow.com/emergency-department-visits-increasing-acep-poll-shows/

16 Reed Abelson et al, May 19, 2018. As an Insurer Resists Paying for 'Avoidable' E.R. Visits, Patients and Doctors Push Back. New York Times. Retrieved from: https://www.nytimes.com/2018/05/19/upshot/anthem-insurer-resists-paying-emergency-room-visits-if-avoidable.html

17 Office of Statewide Health Planning and Development, 2017. Emergency Department Encounters by Expected Payer (2012 to 2016). Retrieved from: https://www.oshpd.ca.gov/documents/PressReleases/2017/ED-Encounters-by-Expected-Payer-2012-2016.pdf.

Therefore, we project that these models will achieve a cost savings that would offset the proposed increases in payment.

VII. CONCLUSION

The stakeholders believe this is a viable, cost-effective Medicaid payment model that could improve access to care in the Medicaid program, improve quality, address health care disparities, reduce unnecessary ER and hospital utilization, and increase the physician workforce. It could improve the overall health care status of a diverse and vulnerable Medicaid population in Stanislaus County. It can be replicated in other areas of the country with large numbers of Medicaid patients and serious physician shortages.

The goals of the project are aligned with key CMS and HHS goals to implement innovative value-based payment systems.

Stakeholders

CMA, SMS believe that the Health Plan of San Joaquin would be an excellent partner to engage in this project given their track record of commitment to timely access and high quality, innovative programs they have already begun. Additional resources would help physicians and the plans to continue to innovate to ensure that CMS is paying for value. The local physician community is aging and extremely motivated to work with the State of California and CMS to attract new physicians to their communities to protect access to care. The physicians are also committed to increase Medicaid participation to improve the overall health of their community. The proposed payment systems can achieve these goals.

Model Success

The probability for improvement under this model is high. Based on the numerous studies recommending that Medicaid rate increases will improve access to care, and the positive improvement in physician participation access in most of the states implementing the Affordable Care Act (ACA) Medicaid primary care rate increase on a timely basis,[18] we believe the goals of this project are achievable.

In addition, many physicians involved in the California County Organized Health System (COHS) models informally report that the plans reimburse physicians at Medicare rates and above, and the result has been more comprehensive physician networks and improved access to care for enrollees. Because access to both primary care and specialty physicians has improved in these COHS plans, they have reduced avoidable emergency department utilization, the number of hospital bed days and many other costs. This cost savings has allowed these plans to continue to pay higher than Medi-Cal rates and improve appropriate access to care. The COHS reimbursement rates and contracts are confidential and

[18] Zuckerman, S; Skopec, L; Epstein, M. 2017. Medicaid Physician Fees after the ACA Primary Care Fee Bump. Urban Institute. Retrieved from: https://www.urban.org/research/publication/medicaid-physician-fees-after-aca-primary-care-fee-bump.

therefore, we were unable to officially obtain the data. We have requested the emergency department utilization and hospital cost data from CMS.

CMS Evaluation

Finally, this is a project that can be comprehensively evaluated by CMS. Physician participation in the Medi-Cal fee-for-service program, physician participation in Medi-Cal managed care plans, and whether physicians are accepting new patients can be tracked by the State Department of Health Care Services, the Medi-Cal plans and assessed through physician surveys. Timely access to care, such as waiting times for physician appointments and urgent care are already tracked and documented in California through the health plans. Patient satisfaction surveys can also be conducted. Measuring the impact of supplemental payments on the retention of physician who completed their residency training can easily be tracked. The current residency programs already collect and report retention information. And changes in Medicaid emergency department utilization, hospital bed days, and other health care condition indicator data should be readily available from CMS.